Complete Summary

GUIDELINE TITLE

Contraceptive choices for breastfeeding women.

BIBLIOGRAPHIC SOURCE(S)

Contraceptive choices for breastfeeding women. J Fam Plann Reprod Health Care 2004 Jul;30(3):181-9; quiz 189. [77 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Prevention

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize contraceptive options and effects of hormonal contraception on breast milk and infant growth
- To provide recommendations and good practice points on which contraceptive methods can be used by breastfeeding women and when to start these methods

TARGET POPULATION

Breastfeeding women considering the use of contraception

INTERVENTIONS AND PRACTICES CONSIDERED

1. Assessing postpartum contraceptive needs and providing women with information on contraceptive options and when to start contraception
2. Contraception:
    - Lactation amenorrhoea method (LAM)
    - Intrauterine device
    - Condoms and spermicides
    - Progestogen–only pills and implants
    - Emergency contraception
    - Progesteron-only injectable (depot medroxyprogesterone acetate [DMPA])
    - Combined oral contraception (COC)
    - Diaphragms and cervical caps
    - Sterilisation (male and female)

MAJOR OUTCOMES CONSIDERED

- Effect of hormonal contraception on lactation, breast feeding, and infant growth
- Contraceptive effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches were performed for: MEDLINE (CD Ovid version) (1960-2003); EMBASE (1960-2003); PubMed (1960-2003); the Cochrane Library (to February 2004), and the US National Guideline Clearing House. The searches were performed using relevant medical subject headings (MeSH), terms, and text words. The Cochrane Library was searched for systematic reviews, meta-analyses, and controlled trials relevant to contraception for breastfeeding women. Previously existing guidelines from the Faculty of family Planning and Reproductive Health Care (FFPRHC), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO), and reference lists of identified publications were also searched. Similar search strategies have been used in the development of other national guidelines.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications were appraised according to standard methodological checklists before conclusions were considered as evidence. Evidence was graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organizations.

Evidence tables (available on the Faculty Web site [www.ffprhc.org.uk]) summarise relevant published evidence on contraception in breastfeeding women, which was identified and appraised in the development of this Guidance.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation are based on levels of evidence as follows:

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the grades of recommendation based on levels of evidence (A-C, Good Practice Point), are provided at the end of the "Major Recommendations" field.

<u>What should a clinician assess when considering contraception for a breastfeeding woman?</u>

- A clinician should assess a woman's postpartum contraceptive needs by taking account of her personal choice, sexual activity, breastfeeding pattern, menstruation, and medical and social factors (Good Practice Point).
- Breastfeeding women should be given information about all hormonal and non-hormonal contraceptive methods (Good Practice Point).
- Breastfeeding women should be offered information and support to use their chosen method of contraception effectively (Good Practice Point).

<u>What are the effects of breastfeeding on ovulation and fertility?</u>

1. Women should be advised that breastfeeding delays the return of ovulation (Grade B).

2. Women should be advised that because breastfeeding delays the return of ovulation, all contraceptive methods have low failure rates when used consistently and correctly (Grade C).
3. Women should be informed that awaiting the onset of menstruation before starting contraception is not advised, as it might put them at risk of unintended pregnancy (Grade B).

<u>What do women need to know about their contraceptive choices: efficacy, effect on breast milk or infant growth?</u>

Lactational Amenorrhoea Method

4. Women may be advised that if they are less than 6 months postpartum, amenorrhoeic, and fully breastfeeding, the lactational amenorrhoea method (LAM) is over 98% effective in preventing pregnancy (Grade B).
5. Women using the LAM should be advised that the risk of pregnancy is increased if breastfeeding decreases (particularly stopping night feeds), when menstruation recurs, or when more than 6 months postpartum (Grade C).

Hormonal Contraception

6. Women should be informed that the level of hormone in breast milk when using a hormonal method of contraception is comparable to levels observed when they have an ovulatory cycle (Grade C).
7. Women should be advised that the available evidence is unable to prove if hormonal contraception has any effect on breast milk volume (Grade C).
8. Women should be advised that the available evidence indicates that hormonal contraception has no adverse effect on infant growth (Grade A).

Combined Hormonal Contraception

9. Women should be advised that use of combined oral contraception (COC) in the first 6 weeks postpartum may have an adverse effect on breast milk volume (Grade B).
10. Breastfeeding women should be advised to avoid COC in the first 6 weeks postpartum (Grade B).
11. Breastfeeding women should be advised that COC can be used without restriction from 6 months postpartum (Grade C).

Breastfeeding women should be advised that COC is not recommended between 6 weeks and 6 months postpartum. However, if breastfeeding is established, COC may be considered if other contraceptive methods are unacceptable (Good Practice Point).

Progestogen-Only Contraception

12. Women should be advised that the use of progestogen-only methods in the first 6 weeks postpartum does not appear to have an adverse effect on breast milk volume (Grade B).
13. Women should be advised that the use of progestogen-only methods when breastfeeding provides over 99% efficacy (Grade B).

14. Women should be advised that the problematic bleeding associated with progestogen-only methods appears to be more acceptable than that experienced by women who are not breastfeeding (Grade B).

After counselling, breastfeeding women may choose to use a progestogen-only method of contraception before 6 weeks postpartum if other contraceptive methods are unacceptable (Good Practice Point).

Non-Hormonal Methods

Intrauterine Device (IUD)

15. Unless an IUD can be inserted within the first 48 hours postpartum, insertion should be delayed until 4 weeks postpartum (Grade C).

Barrier Methods, Spermicides, and Fertility Awareness

16. Women can be advised that the use of diaphragms and cervical caps should be delayed until uterine involution is complete (from 6 weeks postpartum) (Grade C).

When can breastfeeding women be advised to start contraception?

Advice from the Clinical Effectiveness Unit (CEU) on starting contraception postpartum is given in the Table below. This has been adapted from World Health Organization Selected Practice Recommendations for Contraceptive Use (WHOSPR) and the United Kingdom version of this document.

Contraceptive Starting Regimens for Breastfeeding Women

Time postpartum	Contraceptive method	Advice for breastfeeding women on when to start contraceptive method
Immediately	Lactational amenorrhoea method (LAM)	Start immediately postpartum to provide effective contraception. Remind women that the LAM is an interim method effective for the first 6 months postpartum only.
	Intrauterine device (IUD)	Insert within the first 48 hours postpartum to provide immediate protection.
	Condoms and spermicides	Can be used immediately.
	Female sterilisation	Can be performed at the time of Caesarean section if there has been appropriate counselling and consent antenatally.
Under 4 weeks	Progestogen-only pill (POP)	May start any time postpartum. If started up to Day 21 postpartum no additional contraceptive protection required. If started after Day 21 additional contraceptive protection is required for 2 days.

Time postpartum	Contraceptive method	Advice for breastfeeding women on when to start contraceptive method
	Progestogen-only implant	Insert up to Day 28 postpartum without the need for additional contraceptive protection. If inserted after Day 28 additional contraceptive protection is required for 7 days. May be considered before Day 21 if a woman is unlikely to return for insertion, if the risk of pregnancy is high, and if other methods are unacceptable. Counsel regarding bleeding.
	Emergency contraception (EC)	Indicated if there has been unprotected intercourse or potential contraceptive failure after Day 21. Progestogen-only EC can be used without restriction in breastfeeding women.
From 4 weeks	Intrauterine device (IUD)	Insert from 4 weeks postpartum.
	Levonorgestrel-releasing intrauterine system (LNG-IUS)	Insert from 4 weeks postpartum with additional contraception for 7 days.
From 6 weeks	Progestogen-only injectable	Give from 6 weeks postpartum if reasonably certain woman is not pregnant with additional contraceptive protection for 7 days. May be considered at less than 6 weeks if the risk of subsequent pregnancy is high and other contraceptive methods are unacceptable.
	Combined oral contraception (COC)	May be started from 6 weeks if breastfeeding is established and other contraceptive methods are unacceptable. Additional contraceptive protection is required for 7 days.
	Diaphragms and cervical caps	Fit for a new diaphragm or cap from 6 weeks when uterine involution is complete.
	Sterilisation	Male and female sterilisation can be considered after an appropriate interval following pregnancy.

Lactational Amenorrhoea Method

- Women should be advised to start the LAM immediately postpartum (Good Practice point).

Combined Hormonal Contraception

- If breastfeeding is established, a woman who is more than 6 weeks postpartum may start COC at any time if it is reasonably certain she is not pregnant. Additional contraceptive protection is required for 7 days (Good Practice Point).

- Breastfeeding women who are more than 6 weeks postpartum and having regular menstrual cycles can start COC as for non-breastfeeding women (Good Practice Point).
- Women should be advised that the use of COC while breastfeeding is outside product licenses (Good Practice Point).

Progestogen-Only Pills (POP)

- A breastfeeding woman can start a POP up to Day 21 postpartum without the need for additional contraceptive protection (Good Practice Point).
- A breastfeeding woman can start POP after Day 21 postpartum if it is reasonably certain she is not pregnant. Additional contraceptive protection is required for 2 days (Good Practice Point).
- A breastfeeding woman who chooses to use a POP before 6 weeks postpartum should be informed that this is outside the product license for some pills (Good Practice Point).

Progestogen-Only Injectable

17. Breastfeeding women should be advised that depot medroxyprogesterone acetate (DMPA) use before 6 weeks postpartum is not usually recommended (Grade C).
18. Women should be advised that troublesome bleeding can occur with DMPA use in the early postpartum period (Grade C).

Breastfeeding women who choose DMPA will not require the injection until Day 21 postpartum, but if the risk of immediate subsequent pregnancy is high it may be given before this time (Good Practice Point).

Breastfeeding women who choose to use DMPA before 6 weeks postpartum should be informed that such use is outside the product license (Good Practice Point).

Progestogen-Only Implants

- Breastfeeding women may choose to use a progestogen-only implant before Day 28 without the need for additional contraceptive protection (Good Practice Point).
- Breastfeeding women should be advised that the use of a progestogen-only implant before Day 21 postpartum is outside the product license (Good Practice Point).

Levonorgestrel-Releasing Intrauterine System (LNG-IUS)

19. Breastfeeding women may have a LNG-IUS inserted from 4 weeks postpartum (Grade C).

Intrauterine Device

20. Breastfeeding women may have an IUD inserted within the first 48 hours postpartum, otherwise insertion should be delayed until 4 weeks postpartum (Grade C).

Diaphragms and Cervical Caps

21. Breastfeeding women who choose a diaphragm or cervical cap should be advised to wait until at least 6 weeks postpartum before attending for assessment of size required (Grade C).

When do breastfeeding women require emergency contraception (EC)?

- Breastfeeding women can be advised that unprotected sexual intercourse or contraceptive failure before Day 21 postpartum is not an indication for EC (Good Practice Point).
- Breastfeeding women can be advised that once hormonal contraception has been initiated, potential contraceptive failures should be managed in the same way as for women not breastfeeding (Good Practice Point).
- Breastfeeding women may be offered an IUD as EC from 4 weeks postpartum (Good Practice Point).

What follow-up is required for breastfeeding women using contraceptive methods?

22. Breastfeeding women should be advised to return at any time to discuss side effects or other problems, or if they want to change their contraceptive method (Grade C).

Definitions

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C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Potential Benefits

- Appropriate medical advice regarding contraceptive options and effects of hormonal contraception on breast milk and infant growth
- Prevention of unintended pregnancy

Specific Potential Benefits

- The lactational amenorrhea method (LAM) of contraception is over 98% effective in preventing pregnancy in women that are less than 6 months postpartum, amenorrhoeic, and fully breastfeeding.
- The use of progestin-only methods when breastfeeding provides over 99% efficacy in preventing pregnancy.

POTENTIAL HARMS

Progestogen-only method of contraception is associated with bleeding.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Contraceptive choices for breastfeeding women. J Fam Plann Reprod Health Care 2004 Jul;30(3):181-9; quiz 189. [77 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Jul

GUIDELINE DEVELOPER(S)

Faculty of Family Planning and Reproductive Health Care - Professional Association

SOURCE(S) OF FUNDING

Faculty of Family Planning and Reproductive Health Care

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Clinical Effectiveness Unit (CEU): Dr Gillian Penney (Director), Dr Susan Brechin (Co-ordinator); Ms Alison de Souza, and Ms Gillian Stephen (Research Assistants)

Clinical Effectiveness Committee: Professor Anna Glasier (Chair); Dr Chris Wilkinson (ex-officio); Dr David Hicks; Dr Joanne Protheroe; Dr Jo Power; Ms Toni Belfield; Catronia Sutherland

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

Print copies: Available from the Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

Discussion points for contraceptive choices for breastfeeding women and questions developed by the Faculty of Family Planning and Reproductive Health are available at the end of the original guideline document.

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

PATIENT RESOURCES

None available

NGC STATUS

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